

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_\_

Please check leg symptoms you currently have or have experienced in the past 3 months:

	Right	Left
<i>no symptoms</i>	<input type="checkbox"/>	<input type="checkbox"/>
aching	<input type="checkbox"/>	<input type="checkbox"/>
restlessness	<input type="checkbox"/>	<input type="checkbox"/>
heaviness	<input type="checkbox"/>	<input type="checkbox"/>
itching	<input type="checkbox"/>	<input type="checkbox"/>
burning	<input type="checkbox"/>	<input type="checkbox"/>
cramping	<input type="checkbox"/>	<input type="checkbox"/>
throbbing	<input type="checkbox"/>	<input type="checkbox"/>
fatigue	<input type="checkbox"/>	<input type="checkbox"/>
swelling	<input type="checkbox"/>	<input type="checkbox"/>
other: _____	<input type="checkbox"/>	<input type="checkbox"/>

Do your symptoms interfere with sleep?   
Do they interfere with walking?

On a scale of 1-10, with 1 being *slightly bothersome* and 10 being *severely affecting my life*, I consider my vein disease to be:  
1 2 3 4 5 6 7 8 9 10

Are your varicose or spider veins located in another area besides your leg? If so, where?  
\_\_\_\_\_  
\_\_\_\_\_

Please check if **you** have ever had:

	Right	Left
<input type="checkbox"/> leg ulcers	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> bleeding from a vein	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> blood clot/phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> vein surgery	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> prior vein evaluation/treatment	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> vein injections	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> leg injury/trauma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> heart disease	<input type="checkbox"/> high blood pressure	
<input type="checkbox"/> hepatitis	<input type="checkbox"/> HIV (AIDS)	
<input type="checkbox"/> cancer	<input type="checkbox"/> diabetes	
<input type="checkbox"/> migraine		

Do you have a family history of?  
 heart disease     leg ulcers     diabetes  
 varicose veins     clotting disorders

Do you smoke? \_\_\_\_\_. Packs per day \_\_\_\_

Do you drink alcohol? \_\_\_\_\_

OTC Medications/Prescription	Allergies

(Please list on back, if more space is needed)

**For Women only:** (Please check box if yes)

- Are you pregnant or considering pregnancy in the near future?
- Are you breastfeeding?
- worsening of symptoms during pregnancy
- worsening of symptoms around menstrual cycle
- Number of pregnancies? \_\_\_\_\_. Deliveries? \_\_\_\_\_
- Do you use birth control pills or take estrogen replacement therapy? yes/no (circle one)

Check any of the following that are true:

- I have tried elevation of my legs to relieve discomfort for \_\_\_\_\_ months.
  - I have tried elastic support/compression stockings. What type? How long?
- 
- I have taken medication for my leg symptoms. What medication? How long?

- Standing makes my symptoms worse. I stand \_\_\_\_\_ hrs. per day.

Please list any surgeries/hospitalizations (other than vein surgeries) and dates:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list your occupation:  
\_\_\_\_\_

Signature: \_\_\_\_\_